



## ACLA Comment

### “Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options”

#### Report Released from Senate Finance Committee May 20, 2009

The American Clinical Laboratory Association (ACLA) shares the goal of the Senate Finance Committee to develop a reformed health care system that will provide health care coverage for all Americans and - with emphasis on screening, wellness and prevention - significant cost savings. ACLA remains fully committed to working with the Committee on these important and complex issues.

There is a proposed option in the Senate Finance Committee report that runs counter to our shared interest. As discussed on pages 14-15 of the report, imposition of a “uniform” 20% coinsurance for all Medicare Part B services, including preventive and diagnostic clinical laboratory services, is not only at odds with the Senate Finance Committee’s previously stated goals to emphasize prevention and wellness but would shift an entirely new cost burden to Medicare beneficiaries. Clinical laboratory services are currently not subject to Medicare beneficiary co-sharing. In 1984, Congress enacted legislation that expressly removed co-payments from the independent laboratory setting. The rationale supporting that decision is as relevant today as it was previously, for a number of compelling reasons detailed below.

- A new co-pay requirement for laboratory services does not “save” our health care system money because it merely shifts an estimated \$24 billion in healthcare costs from the government to the nation’s most vulnerable seniors. Not only does this proposal dramatically increase seniors out of pocket health care costs, it would, according to the respected Institute of Medicine (IOM)<sup>1</sup>, hit the sickest and poorest seniors the hardest.
- Studies show that minority populations are less likely than the general population to receive preventive screenings but are at increased risk for many of the costly chronic diseases such as diabetes, chronic kidney disease, and heart disease. Instituting a laboratory test co-pay requirement will further cause access issues leading to a widening gap in early detection that will place millions of Americans at increased risk of costly, preventable adverse effects.
- Charging seniors for laboratory co-pays is at odds with Congress’ intent to encourage more prevention and early detection of chronic diseases such as diabetes, heart disease, kidney disease and cancer – and laboratory tests are at the center of prevention and early detection. As stated in the May 20, 2009 Senate Finance Committee’s document *Expanding Health Care Coverage – “Evidence indicates that cost-sharing reduces Medicare beneficiaries’ utilization of preventive services.”*

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<sup>1</sup> Medical Laboratory Payment Policy, Institute of Medicine, 2000

- The average laboratory test co-pay would be \$2.30<sup>2</sup> and the majority of laboratory test co-pays would be *well under \$5.00*. An independent review revealed that it would cost an estimated \$5.00 per bill to collect the co-payment, in many cases exceeding the amount of the co-pay itself. Laboratories would have to rebill beneficiaries in many cases.
- For almost one-third of the 30 most commonly ordered laboratory tests – such as glucose, CBC, cholesterol, and other critical tests for diabetes, heart, kidney and other diseases – the co-pay would be less than \$2.00<sup>2</sup> and significantly below the transaction costs to bill beneficiaries.
- These figures are for the most *commonly ordered* tests. There is another critically important area of testing that, because of their complexity and sophisticated technology, are necessarily more expensive. These are advanced diagnostic tests for cancer and other serious diseases and conditions that are used for early detection and choosing the best treatment that save billions of dollars and save countless lives. Co-payments of 20% for these tests could cost beneficiaries hundreds of dollars or more and provide a true disincentive for beneficiaries to utilize them.
- The IOM report recommended against laboratory co-pays in Medicare. The Committee concluded that “because of the administrative costs and burdens it would impose..., cost sharing for laboratory services is inconsistent with its goals for a laboratory payment system that ensures beneficiary access and maintains administrative simplicity”.

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<sup>2</sup> Since 2003 when these figures were compiled, the laboratory test prices in Medicare have changed little because the Medicare clinical laboratory fee schedule was frozen from 2003 until 2009 when the fee schedule received its lone increase of 4.5%.